Instructions for Preparing and Submitting the FY 2012 Health Center Program Budget Period Progress Report

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I. PURPOSE

In fiscal year (FY) 2011, the Health Resources and Services Administration (HRSA) implemented a streamlined process for grantees applying for non-competitive continuation funding. Under this process, Health Center Program grantees submitted a Budget Period Progress Report (BPR) to allow for a more efficient method of reporting progress in HRSA's Electronic Handbooks (EHB). All Health Center Program grantees requesting non-competitive continuation funding must submit in this manner according to these instructions.

The BPR will be used by HRSA to assess progress and significant changes to approved Health Center Program funded activities. The continuation of grant funding will be based on compliance with applicable statutory and regulatory requirements, timely submission of the BPR through EHB, demonstrated organizational capacity to accomplish the project's goals, Congressional appropriations, and a determination that continued funding is in the best interest of the government.

Grantees are reminded that per section 330(k)(3)(H) of the PHS Act as amended (42 U.S.C. 254b), the health center governing board, including the co-applicant board for public centers, must approve the health center's BPR submission, including the proposed budget for the upcoming project period.

II. SUBMISSION SCHEDULE

The FY 2012 BPR will be generated as a reporting requirement in the Grantee Handbook approximately three months prior to the EHB deadline. The following table provides the FY 2012 BPR deadlines.

Table 1: BPR Deadlines

Budget Period Start Date	EHB Deadline (5:00 PM ET)
November 1, 2011	July 21, 2011
December 1, 2011	August 18, 2011
January 1, 2012	September 22, 2011
February 1, 2012	October 20, 2011
March 1, 2012	November 17, 2011
April 1, 2012	December 15, 2011
May 1, 2012	January 19, 2012
June 1, 2012	February 16, 2012

III. TECHNICAL ASSISTANCE

A technical assistance Web site has been established to assist grantees in completing the BPR. The site includes copies of forms, FAQs, and a slide presentation, among other resources. It can be accessed at http://bphc.hrsa.gov/policiesregulations/continuation.

Grantees may obtain additional information regarding business, administrative, or fiscal issues by contacting:

Donna Marx
Grants Management Specialist
Office of Federal Assistance Management
Division of Grants Management Operations, HRSA
5600 Fishers Lane, Room 12A-07
Rockville, MD 20857
Telephone: 301-594-4245
Email: dmarx@hrsa.gov

Grantees may obtain programmatic technical assistance by contacting:

Cheri Daly
Public Health Analyst
Office of Policy and Program Development
Bureau of Primary Health Care, HRSA
5600 Fishers Lane, Room 17-C26
Rockville, MD 20857
Telephone: 301-594-4300
Email: BPHCBPR@hrsa.gov

Additional technical assistance regarding these instructions may be obtained by contacting the Project Officer noted on the most recent Notice of Award and/or the appropriate Primary Care Associations (PCAs), Primary Care Offices (PCOs), or National Cooperative Agreements (NCAs). A list of these organizations is available at http://bphc.hrsa.gov/technicalassistance/partnerlinks.

IV. REPORTING

All Health Center Program grantees must comply with the following reporting and review activities.

a. Audit Requirements

Health centers must maintain accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP), including separating functions appropriate to organizational size to safeguard assets and maintain financial

stability. Health centers must ensure an annual independent financial audit is performed in accordance with Federal audit requirements, including submission of a corrective action plan addressing all findings, questioned costs, reportable conditions, and material weaknesses cited in the Audit Report. (Section 330 (k) (3) (D), Section 330 (q) of the PHS Act and 45 CFR Part 74.14 (a) (4), 45 CFR Part 74.21 and 45 CFR Part 74. 26) Organizations must submit their audit findings inclusive of the management letter (or provide a signed statement that no letter was issued with the audit) via the process described in Program Assistance Letter 2009-06: New Electronic Process for Submitting Required Annual Financial Audits located at http://bphc.hrsa.gov/policiesregulations/policies/pal200906.html. Failure to submit the audit can result in conditions of award, including draw down restrictions, on available funds.

b. Payment Management Requirements

Submit a quarterly *electronic* Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System (PMS). The report identifies cash expenditures against the authorized grant funds. Failure to submit the report may result in the inability to access grant funds.

c. Status Reports

1. Submit a Federal Financial Report (SF-425) in EHB at the end of each budget period. The report is an accounting of expenditures under the project for that budget period. Grantees will be permitted 90 days to liquidate obligations following the end of the budget period. The report will be due the quarter following the 90 day liquidation period.

2. Submit a Uniform Data System (UDS) Report. Grantees are required to annually submit a Universal Report and, if applicable, a Special Population Grant Report. The UDS is an integrated reporting system used to collect data on all health center programs to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. To facilitate UDS reporting, grantees must have systems in place (e.g., self-report intake forms, screening tools) to collect data on patient characteristics as the UDS requires a count of patients from targeted special populations, including migrant and seasonal farm workers, persons who are homeless, residents of public housing, veterans, and patients served by school-based health centers.

V. INSTRUCTIONS

Grantees are required to submit their BPR within the Grantee Handbook by the applicable FY 2012 BPR deadline. The total size of the BPR must not exceed the equivalent of 60 pages when printed by HRSA, approximately 8 MB. Grantees should submit single-spaced narrative documents with 12 point, easily readable font (e.g., Times New Roman, Ariel, Courier) and 1-inch margins. Smaller font (no less than 10 point) may be used for tables, charts, and footnotes.

Grantees are reminded that failure to include all required documents as part of the BPR will result in the progress report being considered incomplete or non-responsive. Incomplete or non-responsive progress reports will be returned to the grantee through a "request change" notification via EHB to provide missing documentation or clarify a portion of the submitted report. Failure to submit the BPR by the established deadline or submission of an incomplete or non-responsive progress report may result in a delay in Notice of Award issuance or a lapse in funding. Therefore, it is recommended that grantees carefully review their BPR to ensure it is both complete and responsive before submission.

The BPR is a progress report and cannot be used to make changes in scope. A change in scope or budget revision request can be made anytime using the change in scope and/or prior approval requests within EHB.

The forms and documents identified in the following tables are required for the FY 2012 BPR submission. In the Form Type column of Tables 2-5, the word "E-Form" refers to forms that are completed online through EHB and **DO NOT** require downloading or uploading. The word "Document" refers to materials that must be downloaded, completed in the template provided, and uploaded into EHB. The word "Fixed" refers to forms that cannot be altered.

Table 2: BPR Submission

- It is mandatory to follow the instructions provided in this section to ensure that your BPR can be printed efficiently and consistently.
- Failure to follow the instructions may make your BPR non-responsive. Incomplete and non-responsive BPR submissions will be returned for resubmission which may result in a delay in Notice of Award issuance and/or a lapse in funding.
- No table of contents is required.

Progress Report Section	Form Type	Instructions	Counted in Page Limit?
SF-PPR (Required)	E-Form	Complete the form online. Specific instructions are included in the BPR EHB user guide available within EHB and at http://bphc.hrsa.gov/policiesregulations/continuation.	No
SF-PPR-2 (Required)	E-Form	Complete the form online. Specific instructions are included in the BPR EHB user guide available within EHB and at http://bphc.hrsa.gov/policiesregulations/continuation.	No
Budget Information: Budget Details (Required)	E-Form	Complete the form online. Specific instructions are included in the BPR EHB user guide available within EHB and at http://bphc.hrsa.gov/policiesregulations/continuation.	No
Budget Narrative (Required)	Document	Upload the Budget Narrative. Refer to Section VI for detailed instructions.	Yes
Program Specific Forms (Required)	Varies	See Table 3 below. Refer to Appendix A for detailed instructions.	No
Program Specific Information (Required)	E-Forms	See Table 4 below. Refer to Appendix B for detailed instructions.	No
Attachments (Varies)	Documents	See Table 5 below. Refer to Appendix C for detailed instructions. Please note, the Program Narrative Update will be submitted as an attachment.	Yes

Table 3: BPR Program Specific Forms

- **Refer to Appendix A for detailed instructions on completing the forms/documents listed below.**
- The Program Specific Forms **DO NOT** count against the page limit.

Program Specific Forms	Form Type	Instructions
Form 1A: General Information Worksheet (Required)	E-Form	Complete the form online.
Form 1C: Documents on File (Required)	E-Form	Complete the form online.
Form 2: Staffing Profile (Required)	E-Form	Complete the form online.
Form 3: Income Analysis (Required)	Document	Complete the document using the template provided in EHB and upload it as an attachment.
Form 5A: Services Provided (**Read Only**)	Fixed	**This form is pre-populated to reflect the current scope of project and CANNOT be modified.** Any change in scope or self-update will **NOT** be allowed at the time of BPR submission.
Form 5B: Service Sites (**Read Only**)	Fixed	**This form is pre-populated to reflect the current scope of project and CANNOT be modified**. Any change in scope or self-update will **NOT** be allowed at the time of BPR submission.
Form 5C: Other Activities/Locations (**Read Only**)	Fixed	**This form is pre-populated to reflect the current scope of project and CANNOT be modified.** Any change in scope or self-update will **NOT** be allowed at the time of BPR submission.
Form 6A: Current Board Member Characteristics (Required)	E-Form	Complete the form online.
Form 10: Annual Emergency Preparedness Report (Required)	E-Form	Complete the form online.

Program Specific Forms	Form Type	Instructions
Form 12: Organization Contacts (Required)	E-Form	Complete the form online.

Table 4: BPR Program Specific Information

- **Refer to Appendix B for detailed instructions on completing the forms listed below.**
- The Program Specific Information forms **DO NOT** count against the page limit.

Program Specific Information	Form Type	Instructions
Clinical Performance Measures (Required)	E-Form	Complete the forms online. A sample format can be found at http://bphc.hrsa.gov/policiesregulations/continuation.
Financial Performance Measures (Required)	E-Form	Complete the forms online. A sample format can be found at http://bphc.hrsa.gov/policiesregulations/continuation.

Table 5: BPR Attachments

- **Refer to Appendix C for detailed instructions on completing the attachments listed below.**
- **The Attachments WILL count against the page limit.**

Attachments	Form Type	Instructions
Attachment 1: Program Narrative Update (Required)	Document	Upload the Program Narrative Update, highlighting the current status and describing significant changes for all aspects of the overall program.
Attachment 2: Service Area Map (As Applicable)	Document	Upload a map of the service area for the project, noting the organization's service sites (listed in Form 5B).

Attachments	Form Type	Instructions
Attachment 3: Organizational Chart (As Applicable)	Document	Upload a one-page document that depicts the governing board, key personnel, staffing, and any sub-recipients and/or affiliated organizations.
Attachment 4: Position Descriptions for Key Management Staff (As Applicable)	Document	Upload position descriptions for any **VACANT** key management staff positions if the descriptions have changed since the last SAC, NAP, or BPR.
Attachment 5: Biographical Sketches for Key Management Staff (As Applicable)	Document	Upload biographical sketches for any new key management staff hired since the submission of the most recent SAC, NAP, or BPR.
Attachment 6: Summary of Contracts, Agreements, and Sub-Recipient Arrangements (As Applicable)	Document	Upload a BRIEF SUMMARY describing any new or revised contracts and/or agreements.
Attachment 7: Sliding Fee Discount Schedule(s) (Required)	Document	Upload the most current sliding fee discount schedule(s), indicating the most recent review/revision date.
Attachment 8: Other Relevant Documents (As Applicable)	Document	Upload other documents to support the program updates.

VI. BUDGET FORMS INSTRUCTIONS

A complete budget presentation includes the submission of the Budget Information: Budget Details form, a budget narrative, and two Program Specific Forms (Form 2 – Staffing Profile, and Form 3 –Income Analysis). All budget forms must be completed electronically in EHB.

Grantees must note that in the formulation of their budget presentation, per section 330(e)(5)(A) of the PHS Act (42 U.S.C. 254b), the amount of grant funds awarded in any fiscal year may not exceed the costs of health center operation in such fiscal year less the total of: State, local, and other operational funding provided to the center; and the fees, premiums, and third-party reimbursements, which the center may reasonably be expected to receive for its operations in such fiscal year.

The BPR may not be used to request additional Health Center Program funds, including minor capital improvements, or to request changes in the total, type, or allocation of Health Center Program funds.

A. Budget Information: Budget Details Form (Required)

In Section A: Budget Summary, verify the pre-populated list of Health Center Program funding types (i.e., Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC). If the funding types are incorrect, make necessary adjustments. Please note that School Based Health Center is not an allowable selection for the BPR.

In the Federal column, provide the Health Center Program grant request for each Health Center funding type (e.g., CHC, MHC). The total Federal funding requested across all Health Center Program funding types must equal the Recommended Federal Budget figure that appears at the top of the Budget Information: Budget Details form. This figure corresponds with the recommended future support figure (Item 13 or 19) on the most recent Notice of Award, commonly referred to as the ongoing target level of Federal support.

In the Non-Federal column, provide the total of the non-Federal funding sources (e.g. State, local) for each type of Health Center Program (e.g., CHC, MHC). The total for the Non-Federal column should equal the Total Non-Federal Share value on Form 3: Income Analysis. The amount(s) in the Total column will be calculated automatically as the sum of the Federal and non-Federal columns.

In Section B: Budget Categories, provide a breakdown of the budgeted funds (both Federal and non-Federal) by object class category (e.g., Personnel, Fringe Benefits) for each type of Health Center Program funding (e.g., CHC, MHC). Grantees may want to use the Budget Categories form submitted with the most recent BPR or the SF-424A submitted with the most recent SAC or NAP as a reference point, noting that the total value for each Object Class Category may be different from year to year based on programmatic changes. The total for each Health Center Program funding type (e.g.,

CHC, MHC) in Section B should match the total for each Health Center Program funding type (e.g., CHC, MHC) in Section A.

The amounts in the Total Direct Charges row and the Total column will be calculated automatically. Indirect costs may only be claimed with an approved indirect cost rate (see details in the Budget Narrative section below).

In Section C: Non-Federal Resources, provide a breakdown of non-Federal funds by funding source for each type of Health Center Program funding (e.g., CHC, MHC). Please note that if the applicant is a State agency, the State column should be left blank in favor of including State funding in the Applicant column. The total for the Program Income column should equal the Total Program Income value on Form 3: Income Analysis.

B. Budget Narrative (Required)

Include a line-item budget narrative which explains the amounts requested for each row in the Section B: Budget Categories of the Budget Information: Budget Details form. The budget narrative (often referred to as the budget justification) is for **ONE year based on the 12-month budget period following the start date**. Upload the budget narrative in the Budget Narrative Form section in EHB. Refer to the HHS Grants Policy Statement available at http://www.hrsa.gov/grants/hhsgrantspolicy.pdf for information on allowable costs.

The one-year budget narrative must itemize **revenues AND expenses** for each type of Health Center Program funding. Use the budget narrative to clearly explain each line-item within each cost element. The budget narrative must be concise and should not be used to expand the Program Narrative Update (Appendix C: Attachment 1).

NOTE: It is important to ensure that the budget narrative contains detailed calculations explaining how each line-item expense is derived (e.g., number of visits, cost per unit).

Include the following in the budget narrative:

Personnel Costs: Personnel costs must be explained by listing each staff member within scope, position title, percent full time equivalency (FTE), and annual salary. For larger grantee organizations, it is acceptable to group staff as long as such aggregations are sufficiently explained (i.e., list position title(s), percent FTE, and annual salary). Reference Form 2: Staffing Profile as justification for dollar figures, noting that the total dollar figures will not match if any salaries are charged as indirect costs.

Fringe Benefits: List the components that comprise the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement). The fringe benefits must be directly proportional to the portion of personnel costs allocated for the project.

Travel: List travel costs categorized by local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel, and staff members/consumers/board members completing the travel must be outlined. The budget must also reflect travel expenses associated with participating in proposed meetings, trainings, or workshops.

Equipment: List equipment costs and justify the need for equipment to carry out the program's goals. Equipment is defined as an item with a unit cost of $5,000 and a useful life of one or more years. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers or furniture.

Supplies: List the items that the project will use, separating items into three categories: office supplies (e.g., paper, pencils), medical supplies (e.g., syringes, blood tubes, gloves), and educational supplies (e.g., brochures).

Contracts: Provide a clear explanation as to the purpose of each service contract, how the costs were estimated, and the specific contract deliverables. Each grantee is responsible for ensuring that its organization/institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts consistent with the Federal procurement standards set forth in 45 CFR Part 74: Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations or 45 CFR Part 92: Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments, as appropriate.

Other: Include all costs that do not fit into any other category and provide an explanation of each cost (e.g., audit, legal counsel). In some cases, rent, utilities, and insurance fall under this category if they are not included in an approved indirect cost rate.

Indirect Costs: Costs incurred for common or joint objectives which cannot be readily identified but are necessary to organizational operation (e.g., the cost of operating and maintaining facilities, depreciation, administrative salaries). Indirect costs may only be claimed if the grantee provides documentation of an approved indirect cost rate. For institutions subject to OMB Circular A-21, the term "facilities and administration" is used to denote indirect costs. If an organization does not have an approved indirect cost rate, one may be obtained through the HHS Division of Cost Allocation (DCA). Visit http://rates.psc.gov/ to learn more about rate agreements, including the process for applying for them.

C. Form 2 - Staffing Profile

Complete this form for the ***upcoming 12-month budget period***. See Appendix A for detailed instructions.

D. Form 3 - Income Analysis

Complete this form for the ***upcoming 12-month budget period***. See Appendix A for detailed instructions.

APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS

Program Specific Forms ***MUST BE COMPLETED ELECTRONICALLY*** in EHB. **Portions of the Forms that are "blocked/grayed" out are not relevant to the BPR and DO NOT need to be completed.**

FORM 1A: General Information Worksheet (Required)

Form 1A provides a summary of information related to the project, including the service area, target population, service type, and current and projected patients and visits. Current patients/visits refer to the 2010 patient/visit data in UDS. The following instructions are intended to clarify the information to be reported in each section of the form.

1. **APPLICANT INFORMATION**
   Complete all relevant information that is not pre-populated. Use the new Fiscal Year End Date field to select the month in which the grantee organization's fiscal year ends.

2. **PROPOSED SERVICE AREA**
   2a. Target Population and Service Area Designation

   Population Type
   Population types for which funding is requested will be pre-populated based on information provided in the Budget Information: Budget Details form.

   Service Area Designation
   Grantees applying for CHC (section 330(e)) funding MUST provide Medically Underserved Area (MUA) and/or Medically Underserved Population (MUP) designation information. Select the MUA and/or MUP designations that best describe the proposed service area and provide all relevant identification numbers. For inquiries regarding MUAs or MUPs, call 1-888-275-4772 (option 2) or contact the Shortage Designation Branch at sdb@hrsa.gov or 301-594-0816. For additional information, visit the Shortage Designation Web site at http://bhpr.hrsa.gov/shortage/.

   2b. Service Area Type: Select the type (urban, rural, or sparsely populated) that best describes the majority of the target population. If sparsely populated is selected, provide the number of people per square mile (must be 7 or less).

   2c. Target Population and Provider Information: For all portions of this section, report aggregate data for all sites included in the scope of project.

Service Area and Target Population
Provide the estimated number of individuals currently composing the service area and target population. **Note**: The target population numbers must be smaller than or equal to the service area numbers.

Provider FTEs by Type
1. Report the number of provider full-time equivalents (FTEs), paid and voluntary, by staff type. Please note that this number may be different than what was reported in the most recent UDS submission due to additional funding received and/or change in scope. **Provide the count of billable provider FTEs ONLY** (e.g., physician, nurse practitioner, physician assistant, certified nurse midwife, psychiatrist, psychologist, dental hygienist, dentist, social worker).

2. Project the number of billable provider FTEs at the end of the project period based on maintaining the current level of funding.

3. Do **NOT** report provider FTEs functioning outside the scope of project.

Patients and Visits by Service Type
1. List the current number of unduplicated patients and visits. Please note that this number may be different than what was reported in the most recent UDS submission due to additional funding received and/or change in scope.

2. The projected number of patients/visits must be consistent with the projections included in the most recent SAC, NAP, or BPR. Be sure to include any increase in projections based on new awards received in the last budget period (e.g., NAP). **Note: HRSA does NOT expect the number of patients to decline. Any projected decrease must be discussed in the Program Narrative Update.**

3. Do **NOT** report patients and visits for services provided outside the scope of project.

When providing an unduplicated count of patients and visits[1], note the following:
- Visit is defined as a documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. To be included as a visit, services rendered must be documented in the patient's record.

[1] See the UDS Reporting Manual available at http://www.hrsa.gov/data-statistics/health-center-data/reporting/index.html for more information on reporting an unduplicated count of patients and visits.

- Patient is defined as an individual who had at least one visit in the previous year.
- Since a patient must have at least one documented visit, it is not possible for the number of patients to exceed the number of visits.

Patients and Visits by Population Type

1. List the current number of unduplicated patients and visits by population type. Please note that this number may be different than what was reported in the most recent UDS submission due to additional funding received and/or change in scope.

2. Follow instructions #2-3 under ***Patients and Visits by Service Type*** for projecting the number of unduplicated patients and visits by the end of the **UPCOMING** budget period using the Number at End of Year 1 columns.

3. Follow instructions #2-3 under ***Patients and Visits by Service Type*** for projecting the number of unduplicated patients and visits and by the end of the entire project period using the Number at End of Project Period columns.

FORM 1C: Documents on File (Required)
Provide the date that each document was last reviewed/revised. Listed documents must be kept on file at the grantee organization and made available to HRSA **upon request** within 3-5 business days. **DO NOT** include these documents as part of the BPR submission.

FORM 2: Staffing Profile (Required)
Report personnel salaries supported by the total budget for the ***upcoming budget period,*** including those that are part of an indirect cost rate. Include staff for the entire scope of project (i.e., all sites, include volunteer providers). Anticipated staff changes must be addressed in the Program Narrative Update.

- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Do **NOT** report portions of salaries that support activities outside the scope of project.

NOTE: The amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category in the Section B: Budget Categories of the Budget Information: Budget Details form due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

FORM 3: Income Analysis (Required)
Project program income, by source, for the ***upcoming budget period*** by presenting the estimated non-Federal revenues **(all sources of income ASIDE FROM the section**

330 grant funds) for the requested budget. Anticipated changes must be addressed in the **SUPPORT REQUESTED** section of the Program Narrative Update. Entries that require additional explanation (e.g., projections that include reimbursement for billable events that the UDS does not count as visits) must be discussed in the Comments/Explanatory Notes box at the bottom of page 2 of the form and, if necessary, detailed in the budget narrative. Grantees must ***not*** use this form to expand the Program Narrative Update.

The worksheet must be based on the project. ***It may not include funds from pending supplemental grants or unapproved changes in sites, services, or capacity.***

The two major classifications of revenues are as follows:

- **Program Income (Part 1)** includes fees, premiums, third party reimbursements, and payments generated from the projected delivery of services. Program income is divided into Fee for Service and Capitated Managed Care.
- **Other Income (Part 2)** includes State, local, other Federal grants or contracts (e.g., Ryan White, HUD, Head Start), and local or private support that is not generated from charges for services delivered.

If the categories in the worksheet do not describe all possible categories of Program Income or Other Income (e.g., pharmacy), grantees may add lines for additional income sources. Explanations for such additions must be noted in the Comments/Explanatory Notes box at the bottom of page 2 of the form.

NOTE: *Not all visits reported on this form are reported in UDS, and similarly, not all visits reported in UDS are included on this form. This form reports only visits that are billable to patients or third parties, including individuals who, after the sliding fee discount schedule, may pay little or none of the actual charge.*

PART 1: PROGRAM INCOME

Projected Fee For Service Income

Lines 1a.-1e. and 2a.–2b. (Medicaid and Medicare): Show income from Medicaid and Medicare *regardless of whether there is another intermediary involved.* For example, if the grantee has a Blue Cross fee-for-service managed Medicaid contract, the information would be included on lines 1a.-1e., not lines 3a.-3c. If the Children's Health Insurance Program (CHIP) is paid through Medicaid, it must be included in the appropriate category on lines 1a-1e. In addition, if the grantee receives Medicaid reimbursement via a Primary Care Case Management (PCCM) model, this income must be included on line 1e.—Medicaid: Other Fee for Service.

Line 5 (Other Public): Include CHIP **NOT** paid through Medicaid as well as any other State or local programs that pay for visits (e.g., Title X family planning visits, CDC's Breast and Cervical Cancer Early Detection Program, Title I and II Ryan White visits).

Column (a): Enter the number of billable visits that will be covered by each category and payment source: Medicaid, Medicare, other third-party payors, and uninsured self-pay patients.

Column (b): Enter the average charge per visit by payor category. An analysis of charges will generally reveal different average charges (e.g., average Medicare charges may be higher than average Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) charges). If this level of detail is not available, calculate averages on a more general level (i.e., at the payor, service type, or agency level).

Column (c): Enter Gross Charges before any discount or allowance for each payment category calculated as [columns (a)*(b)].

Column (d): Enter the average adjustment to the average charge per visit listed in column (b). A negative number reduces and a positive number increases the Net Charges calculated in column (e). (In actual operation, adjustments may be taken either before or after the bill is submitted to a first or third party.) Adjustments reported here do NOT include adjustments for bad debts which are shown in columns (f) and (g). Adjustments in column (d) include those related to:

1. Projected contractual allowances or discounts to the average charge per visit.
2. Sliding discounts given to self-pay patients (with incomes 0-200% of the FPL).
3. Adjustments to bring the average charge/reimbursement up or down to the:
    a. Negotiated Federally Qualified Health Center (FQHC) reimbursement rate
    b. Established Prospective Payment System reimbursement rate
    c. Cost based reimbursement expected <u>after</u> completion of a cost reimbursement report
4. Any other applicable adjustments. These must be discussed in the Comments/Explanatory Notes box at the bottom of page 2 of the form.

Column (e): Enter the total Net Charges by payment source calculated as [column (c) – columns (a)*(d)]. Net charges are gross charges less adjustments described in column (d).

Column (f): Enter the estimated collection rate (%) by payor category. The collection rate is the amount projected to be collected divided by the amount actually billed. As a rule, collection rates will not exceed 100%, and may be less than 100% due to factors such as bad debts (especially for self pay), billing errors, or denied claims not re-billable to another source. Explain any rate greater than 100% using the Comments/Explanatory Notes box at the bottom of page 2 of the form.
NOTE: *Do not show sliding discount percentages here; they are included in column (d). Show the collection rate for actual direct patient billings.*

Column (g): Enter Projected Income for each payor category calculated as [columns (e)*(f)].

Column (h): Enter the actual accrued income by payor category for the most recent 12-month period for which data are available. Any significant variance between projected income in column (g) and actual accrued income in column (h) must be explained in the **SUPPORT REQUESTED** section of the Program Narrative Update.

Projected Capitated Managed Care Income
This section applies only to capitated programs. Visits provided under a fee-for-service managed care contract are included in the fee-for-service section of this form.

Lines 7a.-7d. (Type of Payor): Group all capitated managed care income types of service by payor on a single line. Thus, capitated Medicaid dental visits and capitated Medicaid medical visits are added together and reported on line 7a.

Number of Member Months (Column a): Member months are the number of member months for which payment is received. One person enrolled for one month is one member month; a family of five enrolled for six months is 30 member months. A member month may cover just medical services, or medical and dental, or a more unique mix of services. Unusual service mixes that provide for unusually high or low per member per month (PMPM) payments must be described in the Comments/Explanatory Notes box at the bottom of page 2 of the form.

Rate per Member Month (Column b): Also referred to as PMPM rate, this is the average payment across all managed care contracts for one member. PMPM rates may be based on multiple age/gender specific rates or on service specific plans, but all these must be averaged together for a “blended rate” for the provider type.

Risk Pool Adjustment (Column c): This is an *estimate* of the *total* amount that will be earned from risk or performance pools, including any payment made by a Health Maintenance Organization (HMO) to the grantee for effectively and efficiently managing the health care of the enrolled members. The estimate is usually for a prior period, but must be accounted for in the period it is received. Describe risk pools in the Comments/Explanatory Notes box at the bottom of page 2 of the form. Risk pools may be estimated using the average risk pool receipt PMPM over an appropriate prior period selected by the grantee.

FQHC and Other Adjustments (Column d): This is the *total* amount of payments made to the grantee to cover the difference between the PMPM amount paid for Medicaid or Medicare managed care visits and the grantee’s PPS/FQHC rate.

Projected Gross Income (Column e): Calculate this for each line as [columns (a)*(b)] + [columns (c)+(d)] = column (e).

PART 2: OTHER INCOME

This section includes **all non-section 330 income not entered elsewhere** on this form. It includes grants for services, construction, equipment, or other activities that support the project, where the revenue **is not** generated from services provided or visit charges. It also includes income generated from fundraising and contributions.

Line 9: Enter income generated by the grantee through the expenditure of its own assets, such as income from reserves or realized sale of property.

Note: In-kind donations **MUST NOT** be included on the Income Analysis form. However, grantees may discuss in-kind contributions in the Program Narrative Update. Additionally, such donations may be included in the Budget Information: Budget Details form (Section A: Budget Summary, Non-Federal column; Section C: Non-Federal Resources).

FORM 5A: Services Provided (Read Only)
Data will be pre-populated from the grantee's official scope of project and **CANNOT** be modified. Any change in scope or self-update will **NOT** be allowed at the time of the BPR submission.

Only services included on Form 5A are considered to be in a grantee's approved scope of project, regardless of what is described or detailed in other portions of the submission. Any service not included on Form 5A requires prior approval via a change in scope request. Refer to the Scope of Project documents at http://bphc.hrsa.gov/policiesregulations/policies for additional information.

FORM 5B: Service Sites (Read Only)
Data will be pre-populated from the grantee's official scope of project and **CANNOT** be modified. Any change in scope or self-update will **NOT** be allowed at the time of the BPR submission.

Only service sites included on Form 5B are considered to be in a grantee's approved scope of project, regardless of what is described or detailed in other portions of the submission. Any service site not included on Form 5B requires an approved change in scope request. Refer to the Scope of Project documents at http://bphc.hrsa.gov/policiesregulations/policies for additional information.

FORM 5C: Other Activities/Locations (Read Only)
Data will be pre-populated from the grantee's official scope of project and **CANNOT** be modified. Any change in scope or self-update will **NOT** be allowed at the time of the BPR submission.

Only other activities/locations included on Form 5C (e.g., home visits, health fairs) are considered to be in a grantee's approved scope of project, regardless of what is

described or detailed in other portions of the submission. Any other activity/location not included on Form 5C requires an approved change in scope request. Refer to the Scope of Project documents at http://bphc.hrsa.gov/policiesregulations/policies for additional information.

FORM 6A: Current Board Member Characteristics (Required)
List all current board members and provide the details requested.

- Tribal organizations are ***not*** required to complete this form.
- Public centers with co-applicant health center governing boards must list the co-applicant board members.
- Grantees with a current waiver of the consumer majority requirement must list the health center's board members, not the members of any advisory council(s).
- All *ex officio* members must be listed. (The CEO may serve only as a non-voting *ex officio* board member.)

FORM 10: Annual Emergency Preparedness Report (Required)
Select the appropriate responses regarding emergency preparedness. This form will be used to assess the status of emergency preparedness planning and progress towards developing and implementing an emergency management plan.

FORM 12: Organization Contacts (Required)
Provide the requested contact information. For the Contact Person field, provide an individual who can represent the organization in communication regarding the BPR submission.

APPENDIX B: PROGRAM SPECIFIC INFORMATION INSTRUCTIONS

A. Clinical and Financial Performance Measures

The Clinical and Financial Performance Measures are performance improvement tools that provide a summary of **PROGRESS** towards the goals identified in the most recently approved SAC, NAP, or BPR. Grantees are required to complete the Clinical and Financial Performance Measures forms in EHB. The Clinical Performance Measures forms **MUST** include one Behavioral Health (e.g., Mental Health or Substance Abuse) and one Oral Health performance measure. For more information regarding the Clinical and Financial Performance Measures, visit http://bphc.hrsa.gov/policiesregulations/performancemeasures. To review specific performance measure details, consult the most recent UDS Reporting Manual available at http://www.hrsa.gov/data-statistics/health-center-data/reporting/index.html.

Important Details about the Clinical and Financial Performance Measures

- Do **NOT** attach the original Clinical and Financial Performance Measures forms. Instead, provide updates on **PROGRESS TOWARD THE GOALS** for each performance measure included in the most recently approved application.
- Revise project period end goals **ONLY IF MAJOR** accelerated progress or barriers were experienced in the previous budget period. Provide specific details of such situations in the Qualitative subfield of the Progress Toward Goal field AND provide the rationale for such revision in the Comments field.

B. New 2011 UDS Performance Measures

For the 2011 UDS Report (to be submitted by March 31, 2012), grantees will be required to report on new and revised Clinical Performance Measures. In preparing the BPR submission, grantees are encouraged to include the new Clinical Performance Measures (Weight Assessment and Counseling for Children and Adolescents, Adult Weight Screening and Follow-Up, Tobacco Use Assessment, Tobacco Cessation Counseling, and Asthma – Pharmacological Therapy) to establish baseline data. Grantees who select “Not Applicable” for these measures should note that they will be required to report on these measures in the 2011 UDS Report.

The revised Clinical Performance Measures (Diabetes and Childhood Immunizations) have not been included in the BPR to allow grantees to report progress on the **unrevised** versions of these measures. However, grantees may begin collecting and reporting information on the revised measures in the BPR submission if desired (**grantees choosing to report on one or both revised measures must note this in the Comments field of the appropriate measure**). Reporting data on the revised measures will be required in the 2011 UDS Report. More information on the new and revised Clinical Performance Measures is available at http://www.hrsa.gov/data-statistics/health-center-data/reporting/index.html.

Table 6: Overview of Clinical and Financial Performance Measures Form Fields

Field	Is this a Pre-Populated Field?	Is this Field Editable?	About this Field
Focus Area	YES	NO	This field contains the content area description for each required Clinical and Financial Performance Measure. The EHB system ***will not allow*** grantees to edit information in this field. However, grantees may specify their own focus area by choosing Other for a new performance measure being added or when specifying Oral Health and Behavioral Health measures.
Performance Measure	YES	NO	This field defines each measure. The EHB system ***will not allow*** grantees to edit information in this field for the required performance measures. However, this field is editable for Oral Health, Behavioral Health, and Other performance measures. Grantees are required to ***provide a justification*** for each edit in the Comments field.
Performance Measure Applicability	YES	YES	The new Clinical Performance Measures (Weight Assessment and Counseling for Children and Adolescents, Adult Weight Screening and Follow-Up, Tobacco Use Assessment, Tobacco Cessation Counseling, and Asthma – Pharmacological Therapy) may be marked "Not Applicable" for the 2012 BPR only. Grantees are encouraged to mark these measures "Applicable" and report available baseline data. The Prenatal Health and Perinatal Health performance measures are the ***only*** Clinical Performance Measures that can be marked "Not Applicable" on an ongoing basis. Such designation requires justification regarding referral and tracking practices (required regardless of applicability) in the Comments field. Grantees that assume primary responsibility for some or all of a patient's prenatal/perinatal care services (those who have selected the first or second columns on Form 5A for these services) are required to include and report on these performance measures. Audit-related Financial Performance Measures may be marked as "Not Applicable" **ONLY** by Tribal or Public Center (formerly referred to as public entity) grantees.
Target Goal Description	YES	YES	This field provides an editable description of the target goal that is pre-populated with information from the most recent SAC, NAP, or BPR. Edits must be justified in the Comments field.

Field	Is this a Pre-Populated Field?	Is this Field Editable?	About this Field
Numerator Description	YES	NO	In the case of the Clinical Performance Measures, the numerator is the number of patients that meet the criteria identified by the measure (e.g., patients in a specified age range that received a specified service). In the Financial Performance Measures, the numerator field must be specific to the individual organizational performance measure. The EHB system ***will not allow*** grantees to edit the numerator for required performance measures. However, this field is editable for Oral Health, Behavioral Health, and Other performance measures. Grantees that edit this field ***must provide a justification*** in the Comments field.
Denominator Description	YES	NO	In the case of the Clinical Performance Measures, the denominator is all patients to whom the measure applies (e.g., patients in a specified age range, regardless of whether they received a specified service). In the Financial Performance Measures, the denominator field must be specific to the individual organizational performance measure. The EHB system ***will not allow*** grantees to edit the denominator for required performance measures. However, this field is editable for Oral Health, Behavioral Health, and Other Performance Measures. Grantees that edit this field ***must provide a justification*** in the Comments field.
Baseline Data Baseline Year Measure Type Numerator Denominator	 YES YES YES YES	 YES YES YES YES	This field contains subfields that provide information regarding the initial threshold used to measure progress over the course of the project period. The Baseline Year subfield identifies the initial data reference point. The Measure Type subfield provides the unit of measure (e.g., percentage, ratio). Although each subfield is pre-populated with data from the most recent SAC, NAP, or BPR, grantees can edit information in these fields (e.g., provide revised data from recently installed EHR system). However, grantees that edit these fields ***must provide a justification*** in the Comments field.
Projected Data	YES	YES	This field is pre-populated with the goal for the end of the project period based on the most recent SAC, NAP, or BPR. The EHB system ***will allow*** grantees to edit information in this field. However, grantees that edit this field ***must provide a justification*** in the Comments field.

Field	Is this a Pre-Populated Field?	Is this Field Editable?	About this Field
Data Source and Methodology	YES	YES	This field is pre-populated with data from the most recent SAC, NAP, or BPR. The EHB system ***will allow*** grantees to edit information in this field. Grantees must cite their data sources and discuss the methodology used to collect data for their performance measures.
Progress Toward Goal Quantitative Qualitative	YES NO	YES YES	Quantitative data is pre-populated from the most recent UDS report. This field is editable; however, grantees that edit this field ***must provide a justification*** in the Comments field. In providing quantitative data, grantees must report on performance measure trends such as percent increases or decreases. **Qualitative information regarding contributing and/or restricting factors that have impacted the grantee's progress during the project period must be provided**. Use the Qualitative subfield to identify new and emerging issues (e.g., target populations, service areas) as related to the performance measures. Responses are limited to 500 characters.
Comments	NO	YES	This is an optional text field in which grantees can provide information regarding their progress toward a particular goal identified for the performance measure. Grantees that indicate that a performance measure is "Not Applicable" are required to provide a justification in this field. Please note that any change in a Baseline Data field requires a justification. This field has a 1,000 character limit. Grantees may use the **EVALUATIVE MEASURES** section of the Program Narrative Update to include any information that exceeds the limit.

C. Behavioral Health and Oral Health Performance Measures

Although the Behavioral Health and Oral Health performance measures are referred to as *"additional measures"* on the performance measures Web site (http://bphc.hrsa.gov/policiesregulations/performancemeasures), grantees are ***required to identify*** at least one Behavioral Health (e.g., Mental Health or Substance Abuse) **and** one Oral Health (e.g., oral health screenings and exams, referrals, dental caries) performance measure defined by a numerator and denominator that can be tracked over time. For Behavioral Health measures, grantees may wish to focus on areas such as behavioral health screening, treatment, and referral or behavioral health patient outcomes (including services provided by behavioral health or primary care providers).

D. Financial Performance Measures

There are five Required Financial Performance Measures. Quantitative data in the first two cost-related measures are pre-populated using the most recent UDS data. Baseline Data, Target Goal Description, Projected Data, and Data Source and Methodology for

all five financial measures are pre-populated from the most recent SAC, NAP, or BPR. Only Tribal and Public Center[2] grantees may indicate the three audit-related Financial Performance Measures (Change in Net Assets to Expense Ratio, Working Capital to Monthly Expense Ratio, and Long Term Debt to Equity Ratio) as "Not Applicable." These grantees may choose to include substitute measures limited to the scope of Federal project (e.g., surplus or loss as a percent of total cost).

E. Other Performance Measures

In addition to the required Clinical and Financial Performance Measures, grantees may identify other measures relevant to their health center and/or target population. For example, grantees may add Clinical Performance Measures that focus on the quality of care for a key service or services provided to patients. Any additional Financial Performance Measures must focus on the organization's financial performance. Additional measures must be quantitative (defined by a numerator and a denominator), and progress must be tracked over time. If a grantee no longer tracks a self-defined "Other" performance measure, the grantee must note this by including a justification in the Comments field as to why reporting is no longer possible and/or relevant.

F. Resources for Performance Measures

Grantees are encouraged to use their Health Center Trend Report and/or Site Summary Report and consider how improvements to their past performance can be undertaken. Grantees may find it useful to examine the performance measures of other health centers that serve similar target populations. Additionally, state and national performance UDS benchmarks and comparison reports (available http://www.hrsa.gov/data-statistics/health-center-data/reporting/index.html) may be helpful when developing health center performance measures.

Uniform Data System

Grantees that have a UDS trend report that reflects their previous performance on a particular measure may use these data to assist in establishing and/or updating performance measure goals. In addition, grantees should consult the most recent UDS Reporting Manual available at http://www.hrsa.gov/data-statistics/health-center-data/reporting/index.html for specific measurement details (e.g., exclusionary criteria for the numerator or denominator of a measure).

Healthy People 2020

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has two major goals: (1) increase the quality and years of a healthy life, and (2) eliminate our country's health disparities. It consists of 38 focus areas containing measurable objectives. Grantees are encouraged to consider the Healthy People 2020 goals and objectives as a guide when developing their Clinical and

[2] See Policy Information Notice 2010-10: Confirming Public Agency Status Under the Health Center Program & FQHC Look-Alike Program located at http://bphc.hrsa.gov/policiesregulations/policies/pin201001.html for the criteria and process HRSA uses to confirm an organization's public agency status.

Financial Performance Measures. Additional information on Healthy People 2020 goals and objectives is available at http://www.healthypeople.gov.

Meaningful Use

The meaningful use (MU) incentive program encourages the use of Electronic Health Records (EHR) to improve the patient's experience of care and provider care coordination, reduce per capita health care costs, and increase population health. Detailed information about MU is available at http://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp. Grantees with MU goals, objectives, and corresponding measures should include this information in the Program Narrative Update of their BPR submission.

APPENDIX C: INSTRUCTIONS FOR ATTACHMENTS

Attachment 1: Program Narrative Update

The Program Narrative Update must address **broad issues and changes** that have impacted the community/target population and discuss progress on the plan outlined in the most recent SAC or NAP (including any changes made based on the last BPR submission). Broad issues and changes include, but are not limited to, changes that impact operations, number of patients/visits, and/or financial viability of the health center. This information is critical as it is utilized by HRSA to monitor grantee progress.

Note: Information **MUST** be provided for each element below. Grantees may not indicate "no change" for any element.

Grantees **must** use the Program Narrative Update to discuss the extent to which program specific requirements continue to be met. Grantees are encouraged to review http://bphc.hrsa.gov/about/requirements for information on key health center program requirements.

The Program Narrative Update must be consistent with the information presented in the Clinical and Financial Performance Measures. Grantees must use the section headings (i.e., **NEED, RESPONSE, COLLABORATION, EVALUATIVE MEASURES, IMPACT, RESOURCES/CAPABILITIES, GOVERNANCE, SUPPORT REQUESTED**) but should NOT repeat the instructions specific to each item in their BPR submissions. Throughout the Program Narrative Update, reference may be made to required attachments and forms, as needed, to reflect information about multiple sites and/or geographic or demographic data. **The attachments must augment, not replace, required narrative.**

The Program Narrative Update must address ***broad issues and changes/progress*** in the following areas.

A. NEED

1. Highlight the **CURRENT STATUS** and describe any **CHANGES** since the last SAC, NAP, or BPR in the target population and service area that affect access to primary health care, health care utilization, and health status. A grantee that does not receive targeted funding to serve migrant and seasonal farm workers (section 330(g)), people experiencing homelessness (section 330(h)), and/or residents of public housing (section 330 (i)), but currently serves or may serve these populations in the future, is encouraged to discuss the unique health care needs of these populations.

2. For grantees receiving targeted funding to serve designated special populations, highlight the **CURRENT STATUS** and describe any **CHANGES** in the following areas, including increases or decreases in the special populations in the service area.

a) **Migrant and Seasonal Farm Workers (section 330(g)):** Highlight the **CURRENT STATUS** and describe any **CHANGES** in the factors (e.g., access barriers, past utilization) related to the health care needs and demand for services of migrant and seasonal farm workers, including:
   - Agricultural environment (e.g., crops and growing seasons, need for labor, number of temporary workers).
   - Approximate period(s) of residence of migrant workers and their families.
   - Migrant occupation-related factors (e.g., working hours, housing, sanitation, hazards including pesticides and other chemical exposures).

b) **People Experiencing Homelessness (section 330(h)):** Highlight the **CURRENT STATUS** and describe any **CHANGES** in the specific health care needs and access issues impacting people experiencing homelessness (e.g., number of providers treating homeless individuals, availability of homeless shelters and/or affordable housing).

c) **Residents of Public Housing (section 330(i)):** Highlight the **CURRENT STATUS** and describe any **CHANGES** in the health care needs and access issues impacting residents of public housing (e.g., availability of public housing).

3. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the primary health care services (including behavioral and oral health) currently available in the service area, including any gaps in service (e.g., provider shortages) and the role and location of other providers who currently serve the target population.

4. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the health care environment that have affected the community's ability to provide services, the target population's ability to access health care, and/or the grantee's fiscal stability. Topics to be addressed may include:
   a) Changes in the availability or level of insurance coverage, including Medicaid, Medicare, and CHIP. Changes in State/local/private uncompensated care programs.
   b) Changes in the economic or demographic environment of the service area (e.g., influx of refugee population; closing of/changes to local hospitals, community health care providers, or major local employers; major emergencies such as hurricanes, flooding, terrorism).

B. RESPONSE

1. Highlight the **CURRENT STATUS** and describe any **CHANGES** made since the last SAC, NAP, or BPR in response to the issues identified in the **NEED** section.

2. Describe the outcome of any change(s) in scope and/or funding approved/awarded since the last SAC, NAP, or BPR, including the date when the change in scope was approved or award was issued. Specifically address reasons for/results of any **CHANGES** in the:

a) Locations where services are provided
b) Hours of operation

Discuss how these changes continue to assure that services are available and accessible at locations and times that meets the needs of the target population.

3. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the accessibility and/or availability of primary health care services for all life cycles without regard to ability to pay. Changes made to the mode of service delivery in the past year via the EHB scope module (direct vs. referral; shifts between any columns on Form 5A) must be described. Specifically address reasons for and results of any **CHANGES** in the clinical operations and patient care services made as a result of organizational or community changes, including:
   a) Provision of required and additional clinical and non-clinical services, including whether these are provided directly or by referral.
   b) How services are culturally and linguistically appropriate (e.g., availability of interpreter/translator services, bilingual/multicultural staff, training opportunities).
   c) Arrangements for admitting privileges for health center physicians at one or more hospitals to ensure continuity of care, discharge planning, and patient tracking among providers.
   d) Professional coverage during hours when the health center is closed.
   e) Referral relationships for additional health services and specialty care with other health care providers with an emphasis on working collaboratively to meet local needs.

4. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the clinical team staffing plan, including the number and mix of primary care physicians, nurse practitioners, physician assistants, certified nurse midwives, oral health providers, behavioral health professionals, social workers, and other providers, as well as clinical support staff necessary for:
   a) Providing services for the projected number of patients.
   b) Assuring appropriate linguistic and cultural competence.
   c) Carrying out required preventive, enabling, and additional health services as appropriate and necessary, either directly or through established arrangements and referrals.

5. Highlight the **CURRENT STATUS** and describe any **CHANGES** in sub-recipient arrangements[3], contracts for a substantial portion of the operation of the health

[3] A sub-recipient is an organization that receives a sub-award from a health center grantee to carry out a portion of the grant-funded scope of project. Sub-recipients must be compliant with all Health Center Program statutory and regulatory requirements, as well as applicable grant requirements specified in 45 CFR Part 74. All sub-recipient arrangements must be documented through a formal written contract/agreement (Section 330(a)(1) of the PHS Act), and a copy must be provided to HRSA in the grantee's competitive application. The grantee must demonstrate to HRSA that it has systems in place to provide reasonable assurances that the

center, and/or other agreements between the grantee and an outside organization, including any change in oversight and authority to assure compliance with Health Center Program requirements. For any required services provided via referral for which the grantee does not pay (third column of Form 5A), the grantee must state that a formal written arrangement/agreement is in place for each such service per Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes (http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html). For **new or revised** arrangements, contracts, and/or agreements, include a summary of the agreements in Attachment 6: Summary of Contracts, Agreements, and Sub-Recipient Arrangements.

Note: All contracts and Memorandums of Agreement or Understanding (MOAs/MOUs) must be kept on file at the grantee organization and must be made available to HRSA **upon request** within 3-5 business days. Do **NOT** include these items with the BPR submission.

6. **Migrant Health Center (section 330(g)), Health Care for the Homeless (section 330(h)) and/or Public Housing Primary Care (section 330(i)) grantees**: Highlight the **CURRENT STATUS** and describe any **CHANGES** in formal arrangements with other organizations that provide services or support to the special population(s) served (e.g., Migrant Head Start, Public Housing Authority, homeless shelters).

7. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the system used to determine eligibility for patient discounts adjusted on the basis of the patient's ability to pay, including any changes or updates to the established schedule of charges and its corresponding schedule of discounts which ensure that no patient will be denied services due to an inability to pay. Attach the current sliding fee discount schedule(s) at Attachment 7.

8. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the organization's ongoing quality improvement/quality assurance (QI/QA) and risk management plan(s). Specifically, address any changes or progress in the following areas:
   a) The clinical director's responsibility in supporting the quality improvement/assurance program and the provision of high-quality patient care.
   b) Periodic assessment of the appropriateness of service utilization, quality of services delivered, and the health outcomes of health center patients.
   c) How the findings of QI/QA assessments have been used to improve organizational performance and what formal institutional mechanisms/processes are in place to ensure this occurs.

9. Highlight the **CURRENT STATUS** and describe any **CHANGES** in board-approved policies and procedures related to:

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sub-recipient organization complies with—and will continue to comply with—all statutory and regulatory section 330 requirements throughout the period of the award.

a) Clinical standards of care.
b) Provider credentials and privileges.
c) Risk management procedures.
d) Patient grievance procedures.
e) Incident management.
f) Confidentiality of patient records.

10. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the health center's short- and long-term strategic plans and how community needs as well as data from the grantee's performance improvement systems (e.g., Clinical and Financial Performance Measures, patient satisfaction findings, QI/QA assessments) have been used to inform the strategic planning process.

11. Describe any **PROPOSED CHANGES** being considered for the **UPCOMING** budget period in services, service sites, provider types, and/or hours of operation based on ongoing strategic planning.

    Note: No change in scope or self-update is allowed in the BPR submission; such changes must be completed in accordance with Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes (http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html).

12. Discuss the organizational response (i.e., actions steps taken) to outstanding grant conditions or terms, including draw down restrictions or any progressive action conditions that will not be resolved by the end of the budget period. In addition, address any actions taken to improve performance as a result of a BPHC-supported site visit or BPHC-supported technical assistance/training session that are not described in the Clinical and Financial Performance Measures.

13. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the organization's ability to:
    a) Maximize FQHC-related benefits (e.g., Federal Tort Claim Act (FTCA) coverage, FQHC Medicare/Medicaid/CHIP reimbursement, 340B Drug Pricing Program, Vaccines for Children Program, National Health Service Corps Providers).
    b) Address BPHC/HRSA-targeted initiatives (e.g., Health Center Accreditation, Health Center Controlled Networks, Patient-Centered Medical/Health Home, National HIV/AIDS Strategy, Accountable Care Organizations).

C. COLLABORATION

1. Highlight the **CURRENT STATUS** and describe any **CHANGES** in both formal and informal collaboration and coordination of services with other health care providers. Specifically discuss collaboration with existing section 330 grantees, FQHC Look-Alikes, relevant Primary Care Associations, rural health clinics, critical access hospitals, other federally-supported grantees (e.g., Ryan White programs), State and local health departments, private providers, and programs serving the same target

populations (e.g., social services; job training; Women, Infants, and Children (WIC); coalitions; community groups).

Grantees may wish to review Program Assistance Letter 2011-02: Health Center Collaboration available at http://bphc.hrsa.gov/policiesregulations/policies/pal201102.html for additional information on maximizing opportunities to collaborate with other health care safety net providers.

2. Provide evidence of **NEW** or **REVISED** collaborations by providing letters of support, commitment, or investment in Attachment 8 that reference the specific collaboration and/or coordinated activities.

D. EVALUATIVE MEASURES

1. Describe **PROGRESS** made on each of the Clinical Performance Measures identified in the most recent SAC, NAP, or BPR in the Progress Toward Goal and Comments fields of the Clinical Performance Measures forms. Do **NOT** repeat information previously provided; instead, discuss overall progress with regard to each performance measure goal. Specifically, grantees must:
   a) Discuss progress toward the goal identified for each Clinical Performance Measure.
   b) Describe contributing and/or restricting factors that impacted progress toward the goal identified for each Clinical Performance Measure.

   Include any information that exceeds the 1,000 character limit of the Comments field in this section of the Program Narrative Update.

2. Describe **PROGRESS** made on each of the Financial Performance Measures identified in the most recent SAC, NAP, or BPR in the Progress Toward Goal and Comments fields of the Financial Performance Measures forms. Do **NOT** repeat information previously provided; instead, report and discuss overall progress with regard to each performance measure goal. Specifically, grantees must:
   a) Discuss progress toward the goal identified for each Financial Performance Measure.
   b) Describe contributing and/or restricting factors that impacted progress toward the goal identified for each Financial Performance Measure.

   Include any information that exceeds the 1,000 character limit of the Comments field in this section of the Program Narrative Update.

E. IMPACT

1. Describe **PROGRESS** made toward the projected number of patients to be served by the end of the project period based on the most recent UDS data compared to the baseline number of patients presented in the most recent SAC, NAP, or BPR. The projected number of patients to be served by the end of the project period must be

consistent with the number presented on Form 1A: General Information Worksheet. Specifically, grantees must discuss:

a) How the trend compares to the number of patients projected in the most recent SAC, NAP, or BPR and any contributing or restricting factors affecting the achievement of the goal. Reference the growth in patients noted in Form 1A in the Number at End of Project Period column of the Patients and Visits by Population Type table. Decreasing trends in patient levels must be fully explained.
b) Grantees that currently receive targeted funding to serve migrant and seasonal farm workers (section 330(g)), people experiencing homelessness (section 330(h)), and/or residents of public housing (section 330(i)) **MUST** discuss reasons for any decrease in the special populations served (e.g., large group of migrant workers no longer working in the service area).
c) Grantees that have received additional funding (e.g., NAP grant awards) during the current project period must identify progress made toward any proposed increase in patients, visits, providers, and/or services. If there have been major problems or start-up delays related to new funding, address these issues.

F. RESOURCES/CAPABILITIES

1. Highlight the **CURRENT STATUS** and describe any **CHANGES** to the organizational structure of the health center (i.e., changes that affect the budget or scope of project[4]), including any NEW or REVISED affiliation agreements/arrangements. Reference Attachment 3: Organizational Chart and Attachment 6: Summary of Contracts, Agreements, and Sub-Recipient Arrangements as applicable.

2. Discuss any **KEY MANAGEMENT STAFF CHANGES** or vacancies in the last year, and describe plans for filling these vacancies. Key management positions include Chief Executive Officer (CEO)[5], Chief Clinical Officer (CCO), Chief Financial Officer (CFO), Chief Information Officer (CIO), and Chief Operating Officer (COO). Specify how long each key management position has been vacant and if a temporary/interim person has been assigned. Reference Attachment 4: Position Descriptions for Key Management Staff and Attachment 5: Biographical Sketches for Key Management Staff as needed.

3. Highlight the **CURRENT STATUS** and describe any **CHANGES** to staffing plans, as well as any contributing or restricting factors encountered during the budget period for recruiting and retaining key management staff and/or health care providers.

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[4] Changes in scope requiring prior approval MUST be submitted through HRSA's Electronic Handbook (EHB). Refer to Policy Information Notice 2008-01: Defining Scope of Project and Policy for Requesting Changes available at http://bphc.hrsa.gov/policiesregulations/policies/pin200801.html.

[5] Prior approval from HRSA is required for a change in the Project Director/CEO through HRSA's Electronic Handbook (EHB) Prior Approval Module.

4. Highlight the **CURRENT STATUS** and describe any **CHANGES** in the acquisition/development and implementation of certified EHR technology systems used for tracking patient and clinical data to achieve meaningful use.

5. Highlight the **CURRENT STATUS** and describe any **CHANGES** to the organization's financial management capabilities, accounting and control systems, policies, and procedures that have impacted the organization's financial status, as well as actions taken to address adverse trends, including:
   a) Actions taken to address adverse financial trends in areas such as expenses, revenue, operating deficit, debt burden, or cash flow.
   b) Changes to financial information systems available for collecting, organizing, and tracking key performance data utilized for supporting management decision making and reporting the organization's financial status (e.g., visits, revenue generation, aged accounts receivable by income source or payor type, aged accounts payable, lines of credit, debt to equity ratio, net assets to expenses, working capital to expenses).

6. Highlight the **CURRENT STATUS** and describe any **CHANGES** related to corrective actions taken to address any findings, questioned costs, reportable conditions, material weaknesses, and significant deficiencies cited in the most recent audit.

7. Highlight the **CURRENT STATUS** and describe any **CHANGES** to systems in place to maximize collection of payments and reimbursement for services, including policies and procedures for eligibility determination, billing, credit, and collection.

8. Highlight the **CURRENT STATUS** and describe any **CHANGES** related to the development and implementation of an emergency preparedness and management plan, including participation in drills or exercises and participation or attempts to participate with State and local emergency planners.

9. Highlight the **CURRENT STATUS** and describe any **CHANGES** related to corrective actions taken based on reports from Office of Inspector General (OIG), Division of Financial Integrity (DFI), and site visits (e.g., operational, diagnostic).

G. GOVERNANCE

Note: Health centers operated by Indian tribes or tribal, Indian, or urban Indian groups, should respond to ONLY Item 5 below.[6]

1. Provide a copy of the health center's signed and dated bylaws in Attachment 8 **ONLY if these have been revised** during the budget period. Discuss the type and purpose of all revisions.

[6] Health Center Program governance requirements do not apply to health centers operated by Indian tribes, tribal groups, or Indian organizations under the Indian Self-Determination Act or urban Indian organizations under the Indian Health Care Improvement Act.

2. Highlight the **CURRENT STATUS** and describe any **CHANGES** to the composition of the governing board, providing reasons for changes in terms of size, expertise, non-patient board member income from the health care industry, and representativeness of the service area/target population and special populations[7] served.

3. Highlight the **CURRENT STATUS** and describe any **CHANGES** made to resolve issues in the following areas:
   a) Meeting monthly, as applicable.
   b) Maintaining a 51 percent consumer/patient majority, as applicable.
   c) Exercising required oversight responsibilities and authorities (e.g., selecting, evaluating, and dismissing the CEO/Executive Director; establishing hours of operation; approving annual budget; conducting board self-assessment).
   d) Training new and existing governing board members.
   e) Evaluating board performance (i.e., processes developed for addressing board needs/challenges, including training needs, communication issues, and meeting documentation)
   f) Using health center performance trend data that is consistent with the Clinical and Financial Performance Measures to inform strategic planning, support ongoing review of the health center's mission and bylaws, evaluate patient satisfaction, review monthly financial and clinical performance, and update sliding fee discount schedule(s)

4. Grantees that **DO NOT** receive Community Health Center (section 330(e)) funds and have an approved waiver for either the 51 percent consumer/patient majority and/or monthly meeting requirement(s) must **PROVIDE AN UPDATE** on the status of their alternative mechanism and discuss how the mechanism continues to meet the intent of the statute by ensuring consumer/patient representation and/or regularly scheduled meetings (as applicable to the type of waiver).

Note: *An approved waiver does not relieve the health center's governing board from fulfilling all other board authorities and responsibilities required by statute.*

5. HEALTH CENTERS OPERATED BY INDIAN TRIBES OR TRIBAL, INDIAN, OR URBAN INDIAN GROUPS: Highlight the **CURRENT STATUS** and describe any **CHANGES** made to the governance structure and how it assures adequate (1) input from the community/target population on health center priorities and (2) fiscal and programmatic oversight of the project.

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[7] A grantee who currently receives funding to serve general community (CHC) **AND** special populations (HCH, MHC, and/or PHPC) must have appropriate representation on the board from these populations. At minimum, there must be at least one representative from each of the special population groups for which the organization receives section 330 funding. Special population representatives should be individuals that can clearly communicate the needs/ concerns of the target population and represent this population on the board.

H. SUPPORT REQUESTED

1. Highlight the **CURRENT STATUS** and describe any **SIGNIFICANT CHANGES**, referencing the budget presentation as needed, that have impacted:
   a) How the total budget is aligned and consistent with the proposed service delivery plan.
   b) The proportion of requested Federal grant funds given other sources of income.
   c) The maximization of reimbursement from third party payors (e.g., Medicare, Medicaid, CHIP, private insurance) and how this relates to any **SIGNIFICANT CHANGES** in the patient and payor mix and/or number of projected patients and visits.

Attachment 2: Service Area Map (As Applicable)

If there have been any changes to the grantee's service area (i.e., **new** service areas added) since the submission of the most recent SAC, NAP, or BPR, upload a current map of the service area, noting the organization's service sites as listed on Form 5B. The map must indicate any medically underserved areas (MUAs) and/or medically underserved populations (MUPs). It must also include other Federally Qualified Health Centers (FQHCs), FQHC Look-Alikes, or other health care providers (e.g., hospitals, private physicians) serving the same target population.

Note: Grantees may wish to access UDS Mapper (http://www.udsmapper.org) and the HRSA Mapping Services and Data Web site (http://www.hrsa.gov/data-statistics/mapping-services-data/index.html) as resources for updating their service area maps.

Attachment 3: Organizational Chart (As Applicable)

If there have been any changes to the grantee's organizational structure since the submission of the most recent SAC, NAP, or BPR, upload a one-page document that depicts the governing board, key personnel, staffing, and any sub-recipients or affiliated organizations.

Attachment 4: Position Descriptions for Key Management Staff (As Applicable)

If position descriptions have changed since the last SAC, NAP, or BPR**,** upload them for any **VACANT** key management staff positions. Key management positions include CEO, CCO, CFO, CIO, and COO, as applicable. Indicate in the descriptions if key management positions are combined and/or part time (e.g., CFO and COO roles are shared). Position descriptions must include the roles, responsibilities, and qualifications for the position and be limited to **one page** or less each.

Attachment 5: Biographical Sketches for Key Management Staff (As Applicable)

If there have been any new key management staff hired since the submission of the most recent SAC, NAP, or BPR, upload biographical sketches if these items have not yet been submitted. Biographical sketches must not exceed **two pages** in length each. In the event that a biographical sketch is included for an individual who is not yet hired, include a letter of commitment from that person with the biographical sketch.

Attachment 6: Summary of Contracts, Agreements, and Sub-Recipient Arrangements (As Applicable)

Upload a summary describing any **new or revised** contracts and/or agreements. Do not discuss contracts and/or agreements for such areas as janitorial services. The summary must address the following items for each contract and/or agreement:

- Name and contact information for each affiliated agency.
- Type of contract and/or agreement (e.g., contract, sub-recipient arrangement, MOU).
- Brief description of the purpose and scope of the contract and/or agreement (i.e., type of services provided through the agreement, how/where services are provided).
- Timeframe for the contract and/or agreement.

Attachment 7: Sliding Fee Discount Schedule(s) (Required)

Upload the current sliding fee discount schedule(s), indicating the date of the most recent review/revision. The sliding fee discount schedule(s) must apply to persons with incomes below 200 percent of the Federal poverty level (see the Federal poverty guidelines at http://aspe.hhs.gov/poverty).

Attachment 8: Other Relevant Documents (As Applicable)

Upload other documents to support the project plan **if there have been any major changes** since the submission of the most recent SAC, NAP, or BPR. Other documents may include facility floor plans, charts, and organizational brochures. Merge all additional items into a single document before uploading.